

Maryland AIDs Drug Assistance Program

Epoetin Alpha Prior Authorization Fax Form

FAX Completed Form to First Health Services Corporation 1-800-932-3921

Questions call First Health Services 1-800-932-3918

Patient's Name: _____

MADAP ID -

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Instructions - In order for a MADAP client to receive epoetin alpha, the client's MADAP certification must remain current and certain medical criteria must be met. For an assessment of the medical criteria, the authorized prescriber must complete and submit this form for approval.

☐ Yes ☐ No Is this a request to continue a course of uninterrupted treatment? If **NO** go to **Initial Approval** section and if **YES** go to the **Continued Approval** section.

Initial Approval - For initial approval of payment for the drug, the physician's statement must indicate that the individual has demonstrated anemia as indicated by a laboratory test showing: a Hemoglobin of less than the equivalent of 11 g/dL **AND** a serum erythropoietin level less than the equivalent of 500 milliunits per milliliter prior to treatment with the drug epoetin alpha; **OR** receiving Hep C treatment with peg-interferon and ribavirin.

Lab values must be obtained within 60 days prior to initiation of treatment with epoetin alpha.

☐ Yes ☐ No Has the patient demonstrated anemia as indicated by a hemoglobin < 11g/dL?

Pre-treatment hemoglobin = _____ g/dL Date: _____

☐ Yes ☐ No Is/Was the serum erythropoietin less than the equivalent of 500 milliunits/ml prior to treatment with the drug epoetin alpha?

Pre-treatment erythropoietin = _____ mU/ml Date: _____

☐ Yes ☐ No Is patient receiving Hep C treatment with peg-interferon and ribavirin

Continued Approval - Lab results must be submitted at 90-day intervals from the Initial PA Approval or the previous Continued PA Approval. The prescriber must state that the individual: (a) has a hemoglobin of less than 13 g/dL after at least 60 days of treatment with epoetin alpha **AND** (b) has adequate serum iron stores as evidenced by either the transferrin saturation or serum ferritin values.

☐ Yes ☐ No The above patient has been re-evaluated since last PA for epoetin alpha

☐ Yes ☐ No Is the patient's transferrin saturation > 20% or serum ferritin ≥ 100 ng/ml obtained within 60 days of the current renewal date?

transferrin saturation = _____ % Date: _____

ferritin = _____ ng/ml Date: _____

☐ Yes ☐ No Has the patient had a serum hemoglobin < 13 g/dL determination at least 60 days after epoetin alpha was begun or in the last 90 days?

Most recent hemoglobin: _____ g/dL Date: _____

Please Note: The dose may be increased to 60,000U/week if Hb rise is <1g/dL after 4 weeks. If Hb does not increase by at least 1g/dL, check iron, folate, and B12 levels. If values are adequate then D/C erythropoietin.

Prescriber Information (please complete legibly)

Name: _____

DEA #

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Address: _____

Office Phone:

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Fax:

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Signature: _____

Date: _____